

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7380

CERTIFICATE OF DEATH

07365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke, Ind. (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DEXTON</u> Middle <u>BONNEVILLE</u> Last <u>BONNEVILLE</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1959</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vernon Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Grace Bonneville</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Grace Bonneville - Pocomoke, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Choking</u> 772.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>6-14</u> , 19 <u>59</u> , to <u>6-17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-17</u> , 19 <u>59</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>Edgar Wharton - New Church, Va.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodtown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1917

DATE OF DEATH
1917

TIME OF DEATH
1917

PLACE OF DEATH
1917

CAUSE OF DEATH
1917

MANNER OF DEATH
1917

AGE
1917

SEX
1917

RACE
1917

EDUCATION
1917

OCCUPATION
1917

RELIGION
1917

DATE OF BIRTH
1917

PLACE OF BIRTH
1917

DATE OF MARRIAGE
1917

PLACE OF MARRIAGE
1917

DATE OF DEATH
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PLACE OF DEATH
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PLACE OF DEATH
1917

FOR STATE
HEALTH DEPT.

7381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07366

Item 7 Filed 6/24/59 at

Reg. Disf. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE Where deceased lived. If institution: Residence before admission a. STATE <i>MD</i>		b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		c. LENGTH OF STAY IN 1b <i>1 7/8 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Showell St</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Payson James Gaines</i>		4. DATE OF DEATH Month <i>6</i> Day <i>20</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OF SKIN <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 10 '02</i>	9. AGE (In years last birthday) <i>56 yrs.</i>	IF UNDER 1 YEAR Months <i>5</i> Days <i>10</i> Hours <i>56</i> Min. <i>56</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Concrete</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME <i>George Gaines</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Emnis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-69-9200</i>		17. INFORMANT <i>Sarah L. Gaines - Berlin</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Suicide by Shotgun</i> DUE TO (b) <i>Probably Temporary Insanity</i> DUE TO (c) <i>Drinking</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Placed the end of gun in mouth and fired trigger - becoming benevolent of God</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <i>6</i> Day <i>20</i> Year <i>1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Berlin</i>		20g. (County) <i>Worcester</i>		20h. (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>N. E. Sartorius</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>6/20/59</i>	
EXAMINER'S NAME (Type) <i>N. E. Sartorius</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-24-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cem</i>	
22d. LOCATION (City, town, or county) <i>Berlin Md</i>		22e. (State) <i>Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Decker Noast</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>DATE JUN 25 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-10

RECEIVED
MEDICAL CENTER
WASHINGTON, D.C.

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The body of the document contains several paragraphs of extremely faint, illegible text, likely typed or printed. The text is too light to transcribe accurately.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7382

CERTIFICATE OF DEATH

07367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	c. LENGTH OF STAY IN 1b <u>1 month</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>422 Pacomake City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Berlin Nursing Home</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>E.</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9 - 1874</u>
9. AGE (In years last birthday) <u>85 1/2</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Shedden, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u> </u>		13. FATHER'S NAME <u>Maris J. Hudson</u>	
14. MOTHER'S MAIDEN NAME <u>Emma A. Jones</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Linda W. Hudson</u> Address <u>Pacomake, City, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> 334X DUE TO <u>Bed Sores</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arthritis</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-15</u> , 19 <u>59</u> , to <u>6-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-15</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford E. Schott</u>		DATE SIGNED <u>3107 Main Berlin Md</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT</u>		<u>3107 N. MAIN BERLIN MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>June 21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Shedden, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Gunni</u>		24. REC'D BY REGISTRAR DATE <u>JUN 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

CERTIFICATE OF DEATH

WILLIAM F. COLEMAN

1

[Faint, mostly illegible handwritten text on a death certificate form. The form includes sections for personal information, cause of death, and medical history.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7383

07368

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seascope Motel</u>		d. STREET ADDRESS <u>5405 Christy Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Ronald Edgar Lowry</u>		4. DATE OF DEATH <u>June 28</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 56</u>
9. AGE (In years and birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HA</u>		14. MOTHER'S MAIDEN NAME <u>Jeanne Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MRS. Jeanne Lowry (Mother)</u>		Address <u>5405 Christy Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning, Accidental</u> DUE TO <u>929.8</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. IMMEDIATE CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in pool while playing</u>	
20c. TIME OF INJURY Month, Day, Year <u>1240 p.m. JUN 18 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, public place, etc.) <u>Seascope Motel</u>		20f. (City or town) <u>Ocean City</u> (County) <u>WA</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. J. Townsend Jr.</u>		DATE SIGNED <u>JUN 28 59</u>	
EXAMINER'S NAME (Type) <u>R. J. Townsend Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>	

1. Name of deceased: *John Doe*
2. Age: *45*
3. Sex: *Male*
4. Date of death: *Jan 15, 1912*
5. Place of death: *Home*
6. Cause of death: *Heart failure*

7. Disease or condition: *Coronary artery disease*
8. Duration of illness: *Several months*
9. Name of attending physician: *Dr. J. Smith*
10. Name of medical examiner: *Dr. J. Smith*

11. Name of coroner: *John Doe*
12. Name of jury: *John Doe, John Smith, John Brown*
13. Name of witness: *John Doe*
14. Name of physician: *Dr. J. Smith*
15. Name of medical examiner: *Dr. J. Smith*

16. Name of coroner: *John Doe*
17. Name of jury: *John Doe, John Smith, John Brown*
18. Name of witness: *John Doe*
19. Name of physician: *Dr. J. Smith*
20. Name of medical examiner: *Dr. J. Smith*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7384

CERTIFICATE OF DEATH

07369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 2				d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GARY Middle LEE Last MORRIS				4. DATE OF DEATH Month 6 Day 1 Year 1959			
5. SEX MALE		6. COLOR OR RACE AA.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-1958	
9. AGE (In years last birthday) yrs. 13		IF UNDER 1 YEAR Months 13 Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard Morris				14. MOTHER'S MAIDEN NAME Constance Rogers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 				16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Constance Morris, Berlin, Md Rt #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X Convulsive seizure DUE TO (b) Cerebral palsy DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 							INTERVAL BETWEEN ONSET AND DEATH 8 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) (County) (State) 							
21. I certify that I attended the deceased from 4-8-1958 to 5-31-1959 , that I last saw the deceased alive on 5-31-1959 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ivory U. Sullivan, M.D.				ADDRESS (Street, city or town, state) Berlin Md			
DATE SIGNED 6/3/59							
PHYSICIAN'S NAME (Type) Ivory U. Sullivan, M.D.				Berlin, Md			
22a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL		22b. DATE THEREOF 6/3/59		22c. NAME OF CEMETERY OR CREMATORY NEW BETHEL Cem.		22d. LOCATION (City, town, or county) BERLIN, MD. (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart				ADDRESS FUNERAL HOME, Salisbury, Md		24a. REC'D BY REGISTRAR Arthur S. Kraus 24b. REGISTRAR'S SIGNATURE DATE JUN 10 '59	

7385

CERTIFICATE OF DEATH

07370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAVENIA (LOVEY) PHILLIPS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 2, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11c. BIRTHPLACE (State or foreign country) <u>BERLIN MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSHUA SHORT</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA BOWEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>1</u>	
17. INFORMANT <u>MR. IRA PHILLIPS</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C-V renal disease</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 June 1955</u> to <u>10 June 1959</u> , that I last saw the deceased alive on <u>10 June 1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. F. Thomas</u> M.D.		ADDRESS (Street, city or town, state) <u>Ocean City, Md 21825</u> DATE SIGNED <u>6-1-59</u>	
PHYSICIAN'S NAME (Type) <u>S. F. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Russell A. Burbage</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

7386

07371

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stocketon, Rural #1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stocketon</u>	
c. LENGTH OF STAY IN 1b <u>35 yrs</u>		d. STREET ADDRESS <u>Rural #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isma</u> Middle <u>M.</u> Last <u>Pilchard</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15 - 1886</u>
9. AGE (In years last birthday) <u>73 3/4</u>		IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>4</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New Church, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Manner</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr Raymond L. Pilchard, Stocketon, md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral degeneration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
4X DUE TO		(b) <u>Arteriosclerosis</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>June 11 1959</u> , that I last saw the deceased alive on <u>June 10, 1959</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. E. Pritchard</u> M. D.		DATE SIGNED <u>June 15 1959</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>June 14/59</u>	
23. NAME OF CEMETERY OR CREMATOR		24. LOCATION (City, town, or county) (State)	
<u>Shenandoah Cemetery</u>		<u>Shenandoah, Va</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Ginn</u>		ADDRESS <u>Snow Hill, md</u>	
26. REC'D BY REGISTRAR		27. REGISTRAR'S SIGNATURE	
DATE <u>JUN 15 '59</u>		<u>Arthur S. Kneass</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)
SM 9/55

7387

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07372

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WOR</u>			
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ocean City</u>		4. LENGTH OF STAY IN 1b <u>Lifetime</u>		5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ocean City</u>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 1 - West Ocean City</u>				8. STREET ADDRESS <u>Rt 1 West Ocean City</u>			
9. NAME OF DECEASED (Type or print) First Middle Last <u>Joshua ARTER Quillen</u>				10. DATE OF DEATH Month Day Year <u>JUNE 16 1959</u>			
11. SEX <u>M</u>		12. COLOR OR RACE <u>W</u>		13. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		14. DATE OF BIRTH <u>JUNE 25 1895</u>	
15. AGE (In years last birthday) <u>83</u> yrs.		16. IF UNDER 1 YEAR Months Days Hours Min.		17. IF UNDER 24 HRS. Months Days Hours Min.			
18a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				18b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		19. BIRTHPLACE (State or foreign country) <u>RI Ocean City, RI</u>	
20. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
21. FATHER'S NAME <u>JOSEPH QUILLEN</u>				22. MOTHER'S MAIDEN NAME <u>Sara Griffin</u>			
23. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				24. SOCIAL SECURITY NO. <u>VERNON Quillen</u>		25. INFORMANT Address <u>Ocean City, Md.</u>	
26. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION, acute.</u> DUE TO <u>Atherosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>159 years.</u>							
27. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>It was treated for chronic congestive failure 2 weeks ago.</u>							
28a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				28b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
29a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		29b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		29c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		29d. (City or town) (County) (State)	
30. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
31. ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.				32. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
33. EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr.</u>				34. DATE SIGNED <u>JUNE 16, 1959.</u>			
35a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		35b. DATE THEREOF <u>6/18/59</u>		35c. NAME OF CEMETERY OR CREMATORY <u>Buckingham</u>		35d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
36. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>				37. ADDRESS <u>Berlin Md</u>		38. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	
				39. REGISTRAR'S SIGNATURE <u>William S. Flowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7379

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CERTIFICATE OF DEATH

07373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
c. LENGTH OF STAY IN 1b <u>All his life</u>		d. STREET ADDRESS <u>RED #2 Bx. 304</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eben</u> Middle <u>Harrison</u> Last <u>Quinn</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28/1888</u>
9. AGE (In years from birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Quinn</u>		14. MOTHER'S MAIDEN NAME <u>Kessie Melvin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-C9-1730</u>	
17. INFORMANT <u>Bessie Quinn</u>		Address <u>Pocomoke City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Essential Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mths.</u> <u>2 yrs.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes m</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/27/57</u> 19 <u>57</u> to <u>6/20/</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6/20/</u> 19 <u>59</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u> Cecil A. Duverney M.D. </u>		ADDRESS (Street, city or town, state) <u>801 - 4th St, Pocomoke</u>	
PHYSICIAN'S NAME (Type) <u>CECIL A. DUVERNEY</u>		DATE SIGNED <u>6/23/59</u>	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u> </u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar A. Shorter</u>		ADDRESS <u>New Windsor</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Frank</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
DATE <u>JUN 29 '59</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

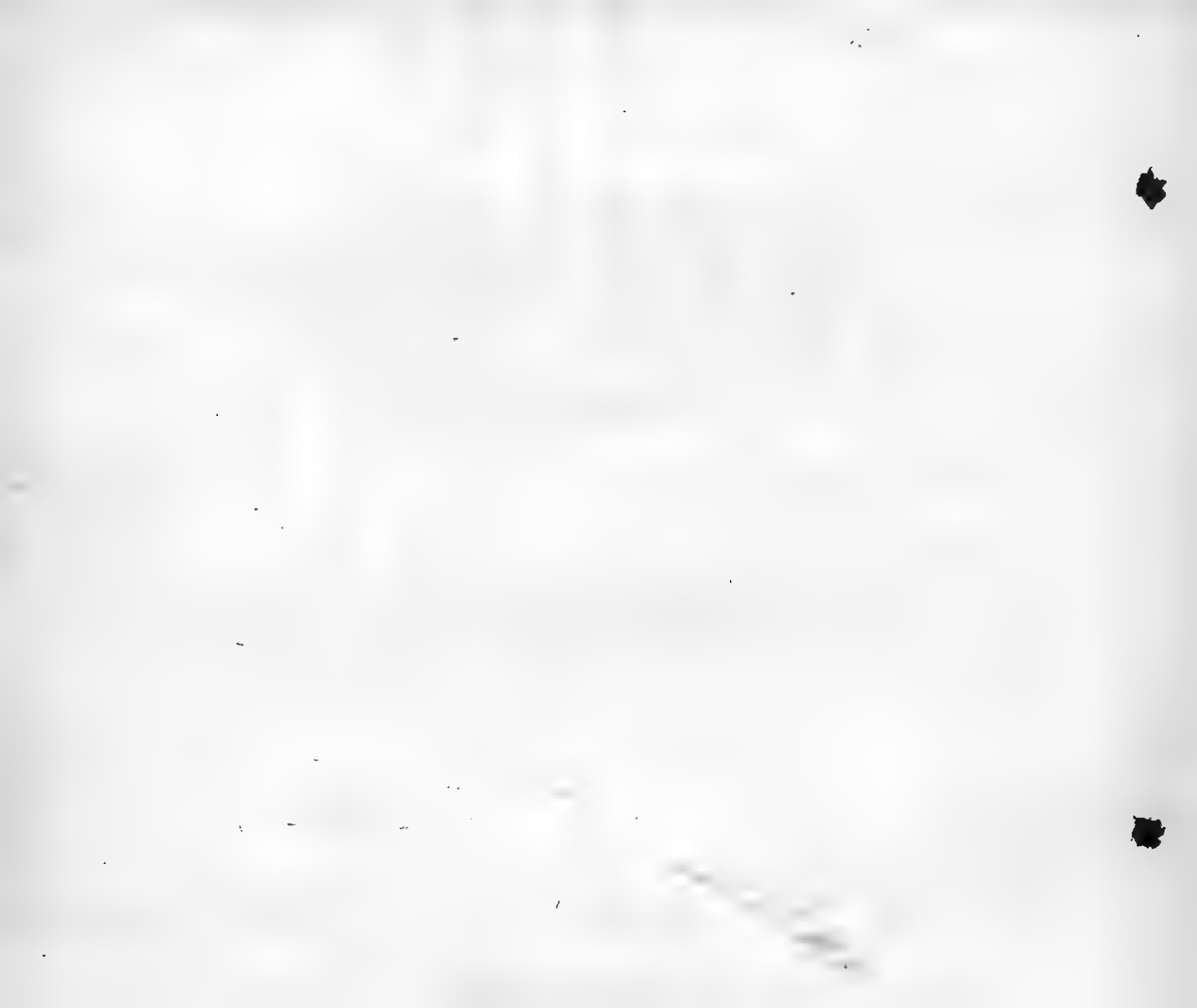
7388

CERTIFICATE OF DEATH

117374

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Redden</u> Last <u>Redden</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 18, 1874</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>85</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Redden</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Collins</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Clara Tull Stockton, Md.</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Hypertensive Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day.</u> <u>3 years.</u> <u>4 years.</u>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Electrolyte Imbalance</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u>19</u> o m. p m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15-57</u> , 19 <u>57</u> , to <u>6-26-1959</u> ; that I last saw the deceased alive on <u>6-26-1959</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>Bevil A. Duverney, M.D.</u>		DATE SIGNED <u>7/8/59</u>		
PHYSICIAN'S NAME (Type) <u>BEVIL A. DUVERNEY</u>		ADDRESS (Street, city or town, state) <u>801 - 4th St., Pocomoke, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)	
<u>Burial</u>	<u>7-4-59</u>	<u>Home Beneficial Ceme.</u>	<u>Stockton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whorton - New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinard</u>	



7389

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Police Barracks, Dorchester St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Bates Roberson</u>				4. DATE OF DEATH Month Day Year <u>June 16 1959</u>			
5. SEX <u>M</u>		6. COLOR OF RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 1889?</u>	
9. AGE (In years last birthday) <u>69</u> yr.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>CHARLES B ROBERSON</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE THOMAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-18-4181</u>			
17. INFORMANT <u>F.E. McFarland</u> Address <u>Police Barracks Ocean City, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY Thrombosis Acute</u> DUE TO <u>Arteriosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 years</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Townsend Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>F.E. TOWNSEND JR.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. DATE OF CREMATION, BURIAL, or REMOVAL (Specify)		22b. DATE THEREOF <u>JUNE 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEM PARK</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LECOMPT FURNERAL SERVICE CAMBRIDGE MD</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 101.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>154 F. BALTIMORE AVENUE</u>		d. STREET ADDRESS <u>1105 Rosemont Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>O. A.</u> Middle <u>W. A.</u> Last <u>W. A.</u>		4. DATE OF DEATH <u>June</u> Month <u>5</u> Day <u>19</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1912</u> 78
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1st Lt. U.S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles L. W. A. W. A.</u>		14. MOTHER'S MAIDEN NAME <u>LIA MARY LONG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-10-100000</u>	
17. INFORMANT <u>ERMA W. A. W. A.</u> Address <u>Frederick, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC DYSPEPSIA ACUTE</u> <u>416X</u> DUE TO <u>CHRONIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (b) <u>CHRONIC HEART DISEASE</u> (c) <u>CHRONIC HEART DISEASE</u> stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>416X</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frederick W. A. W. A.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frederick W. A. W. A.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 15 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. W. S. F. R. A.</u>	

7391

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #2				d. STREET ADDRESS RFD #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLLIE Middle THOMAS Last SCHOOLFIELD				4. DATE OF DEATH Month June Day 21 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1945		9. AGE (In years last birthday) 13 yrs.	IF UNDER 1 YEAR Months 13 Days 13	IF UNDER 24 HRS. Hours 13 Min. 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen Schoolfield				14. MOTHER'S MAIDEN NAME Frances Merrill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Stephen Schoolfield, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning (accidental) X 50X DUE TO falling into Pocomoke River from motor boat Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Motor boat was overturning in river PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Motor boat was overturning in river							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat overturned while crossing a point					
20c. TIME OF INJURY Hour 6 o. m. 25 p. m. Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pocomoke River		20f. (City or town) Pocomoke		20g. (County) Worcester	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE N. E. Sartorius, Sr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/23/59	
EXAMINER'S NAME (Type) N. E. SARTORIUS, SR.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-24-59	22c. NAME OF CEMETERY Unionville M. E.		22d. LOCATION (City, town, or county) (State) Rural Pocomoke City, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thaw

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

to copy the notes
and send them to
the printer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

7392

07378

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Route # 2</u>		c. LENGTH OF STAY IN 1b <u>36 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>G.</u> Last <u>Shackley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 16 1903</u>		9. AGE (In years last birthday) <u>55 1/2</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Winton, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel E. Shackley</u>				14. MOTHER'S MAIDEN NAME <u>Georgia G. Hayden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-362347</u>		17. INFORMANT <u>Mrs Maude G. Shackley, Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma right lung metastasis.</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> 19 <u>59</u> , to date of death, 19 <u>59</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>59</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Lewis</u>				ADDRESS (Street, city or town, state) <u>M.D. Millard Maryland</u>		DATE SIGNED <u>6-20-59</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, county) (State)	
<u>Burial June 23/59</u>		<u>MD</u>		<u>3rd Cemetery</u>		<u>Snow Hill Route #2 MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Sumner</u>				ADDRESS <u>Snow Hill, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Hines</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 23 59</u>							

11-27-71

WESTLAND STATE OF MICHIGAN
CERTIFICATE OF DEATH

1971

FILE NO.

DATE

TIME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF JUDGE

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILE CLERK

NAME OF ASSISTANT

NAME OF CLERK

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

07379
Reg. Dist. No.

7393

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>		c. LENGTH OF STAY IN 1b <u>93 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>J.</u> Last <u>TOWNSEND</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 23, 1866</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSIAH TOWNSEND</u>				14. MOTHER'S MAIDEN NAME <u>MARY J. VANDONGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NO</u>		17. INFORMANT Address <u>Mrs. A. J. TOWNSEND NEWARK MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac failure</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>uremia</u> DUE TO (c) <u>possible carcinoma of kidney or bladder</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2-3 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>senility and severe atherosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>June 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>59</u> , and that death occurred at <u>5:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Grubb MD</u>		ADDRESS (Street, city or town, state) <u>BERLIN, MD</u>		DATE SIGNED <u>6/29/59</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>			

1037

CERTIFICATE OF DEATH

32

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		45		Jan 15 1900		New York City	
Cause of death		Disease		Organ		Time of death		Signature of physician	
Heart failure		Myocarditis		Heart		10:30 AM		J. Smith	
Occupation		Education		Religion		Marital status		Signature of registrar	
Teacher		High School		Catholic		Married		M. Jones	
Place of birth		Date of birth		Place of death		Time of death		Signature of registrar	
New York City		Jan 1 1855		New York City		10:30 AM		M. Jones	
Signature of physician		Signature of registrar		Signature of physician		Signature of registrar		Signature of physician	
J. Smith		M. Jones		J. Smith		M. Jones		J. Smith	

